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Homelessness and Mental Disorders

A Comparative Review of Populations in Various Countries

Many homeless people suffer from mental illnesses such as depression, schizophrenia, substance abuse, psychotic disorders, and personality disorders. The prevalence of those disorders among homeless populations varies from country to country; and the precise cultural, national, psychosocial, and neurobiological determinants of these differences remain unclear. However, trends in mental disorders, homelessness, drug abuse, and crime suggest that Western industrial societies are becoming increasingly harmful to psychological and social well-being [1].

The population of homeless persons is very diverse: it includes representatives from all ethnic groups, the young and the old, women and men, single persons and families, people from both urban and rural environments, and people with physical and/or mental problems [2, 3]. Most of the homeless women and men in the American and European populations are between 31 and 50 years of age, are unmarried, and are unemployed [4–8].

Women head 90 percent of homeless families [9]. Homeless women are a heterogeneous group, largely younger and socially

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more stable than homeless men. Proportionally more homeless females than males have major mental illness. The proportion of women among the adult homeless population increased throughout the 1970s and 1980s, and is currently estimated to be between 10 percent and 25 percent. Women and children are now the fastest growing segment of the homeless population in the United States. These women are restless rather than rootless [10]. Many homeless mothers use illegal drugs and/or alcohol. Fifty-two percent of the children under six years of age from homeless families might have developmental lags, and many homeless children over four years old might have behavioral problems [11].

Compared with their younger homeless counterparts, older homeless persons are more likely to be white and male, to report lower incomes and poorer health, and to meet the criteria for lifetime alcohol-use disorder. Fewer older than younger subjects met criteria for lifetime drug-use disorder and posttraumatic stress disorder. Older and younger homeless persons have different vulnerabilities in terms of mental disorders [12]: 13 percent of the men and 3 percent of the women with such disorders were 50 years of age or older.

Many homeless people suffer from physical health problems. Homeless children in an American population have been reported to experience a high number of acute-illness symptoms, including fever, ear infections, and diarrhea [13]; in general populations in America and Australia, asthma [14, 15] and cardiovascular diseases [16], cuts, and gynecologic problems [17] have been found, as have bronchitis and gastroenteritis [15] in an Australian sample. In a Japanese research population, liver diseases (linked to alcoholism), diabetes mellitus, fractures, dislocations, sprains, strains, hypertension, and cerebrovascular disease were prevalent [18]. Furthermore, in America, Australia, Japan, Siberia, and Spain [15, 18–23], the most important risk for tuberculosis is homelessness. Homeless mothers reported high levels of bodily pain and had a relatively high prevalence of asthma, tuberculosis (33 percent), anemia, and ulcer disease [13]. American homeless youths [24–26], particularly homeless, illegal, sex workers [27], and adults [23] and homeless people in a Spanish sample [28] run an increased

risk for HIV infection. HIV is sometimes linked to tuberculosis [21]. Alderman and coworkers [29] discovered that homelessness in American males and females (between 13 to 21 years of age) was significantly associated with hepatitis B infection.

The prevalence of mental disorders among homeless populations in various countries and the association between homelessness and mental disorders, victimization, and criminality are the focus of this paper.

Risk factors for homelessness

Although policy-makers are likely to explain homelessness as a result of personal or subgroup failings, there are many factors that contribute to the process of becoming homeless. Often a complex combination of mental, physical, social, and economic problems plays a role in this process [30]. The following, some of which admittedly overlap, may contribute to homelessness:

—Feeling unloved in childhood [31], adverse childhood experiences [31–33], and general unhappiness in childhood [34] are powerful risk factors for adult homelessness. Sleegers and associates [35] reported that all but one of a homeless research sample claimed to have experienced one or more adverse life events, and 56 percent reported more than four such events.

—Social poverty can be observed in many homeless persons, although its appearance differs from one subgroup to another; it often derives from long exposure to demoralizing relationships and unequal opportunities [36].

—Economic poverty [37, 38] is a major factor in precipitating homelessness. As a result of limited commitment of resources to safety-net services in market-oriented, industrial nations, some people fall into extreme poverty and homelessness. Lack of appropriate employment possibilities and of public support of the poor and reduced availability of low-cost housing are the primary reasons for the increase in homelessness since the late 1970s [2, 6, 7].

—Mental disorders [32], previous presence of such a disorder, or recent hospitalization for a mental health problem [39] can lead

to homelessness; one-third of the homeless adults in the United States, Great Britain, Australia, and Canada were found to have a prior history of psychiatric hospitalization [40]. Recent substance abuse, depression [41], schizophrenia [42], and other mental disorders or mental health problems [43–45] and a number of stressful life events [34] have all been reported by the homeless.

—Low levels of support by friends [41] or relatives is common among the homeless.

—Among young people, physical and/or sexual abuse before leaving home [31, 46–48] has been reported.

—Residential instability [32, 38] is a common characteristic of the homeless.

—Parental divorce, antisocial behavior [31, 49], and substance abuse [31, 34, 39, 49] can be contributing factors.

—A history of drug and/or alcohol abuse [45] is common.

—Delinquent behavior, expulsion from school, and/or placement in reform school [45] may precede homelessness.

—Foster-care placement (15 percent) [39, 50] or group home placement (10 percent) [50] in the past may be a factor: 58 percent of homeless adolescents had experienced some kind of out-of-home placement [39], running away (20 percent) [50], or early departure from home [31, 45].

Other contributing factors include: low educational level [32]; minority status [31, 45]; low parental educational level and/or less-skilled parental jobs [31]; less likelihood of a father in the home [31]; high birth order in a large family [31]; less likelihood of identification with a religious group [31]; family conflict [51, 52], family problems [37], or interpersonal conflict [39]; *lack* of protective factors such as being a primary tenant, receiving cash assistance or a housing subsidy, graduating from high school, and having a relatively large social network [39].

Most subjects in Muñoz and coworkers' [72] samples of the homeless in Madrid, Spain, and Los Angeles, United States, first experienced symptoms of mental disorders before their initial period of homelessness. Winkleby & White [73] found that respondents who reported no impairments when they first became homeless were likely to develop mental disorders over time (See Table 1).

Table 1

Homelessness and Mental Disorders: Rates in Various Countries

Mental disorders among the homeless	Percent
United States (USA) [6, 53–58]	2–91
Canada (CAN) [59–63]	20–90
Australia (AUS) [15, 64–67]	25–82
Ireland (IRE) [68]	25
France (FRA) [69]	57.9
Netherlands (NET) [35]	78
Norway (NOR) [70]	82
Spain (SPA) [57]	33
Germany (GER) [43]	94.5
Great Britain (GB) [32, 71]	55

Table 2

Homelessness and Mental Disorders: Rates in Various Countries

Depression among the homeless	Percent
USA [57, 72, 74]	25–35, 23.1, 4–9
CAN [63]	46.3(m), 60(f)
AUS [15]	49
FRA [69]	33.7
NET [35]	22
IRE [3]	2.9(m), 14.3(f)
SPA [57,72]	20, 27.7
GER [8]	4.6

Note: m = males; f = females.

All of the depressed adults in the Spanish (Madrid) sample experienced depression before initially becoming homeless, whereas this was the case for only 59.1 percent of the American (Los Angeles) depressed homeless people [72] (See Table 2).

Among adolescents, homelessness was an independent predictor of depression [75]. Menke & Wagner [76] found that school-age children who were experiencing homelessness for the first time might be at considerable risk for depression and anxiety: they had

significantly higher anxiety scores than children who had never been homeless or who had previously experienced homelessness. Auyerst [77] observed that stress and depression were positively correlated for Canadian (runaway) street youth. Moreover, these runaway youths often displayed self-harm.

Lam & Rosenbeck [78] found that the quality of life of homeless mentally ill clients was related to the severity of depressive symptoms. Isolation from social networks increased depression levels among homeless mothers, and health services had little impact on their depressive symptoms [79].

Anxiety rates among homeless people in Germany [43], the Netherlands [35], and Canada [68] were reported to be 26.6 percent, 22 percent, and 35.1 percent (for males) and 28.9 percent (for females), respectively.

Ducq and coworkers [40] reported rates for *affective disorders* among homeless persons in Canada, Great Britain, and the United States ranging from 4 percent to 74 percent. Rates for France [69], Germany [48], and the Netherlands [35] were 41 percent, 41.8 percent, and 24 percent, respectively. For *psychotic disorders*, Ducq and associates [40] found a range up to 70 percent for Australia, Canada, Great Britain, and the United States. Other investigators reported varying rates of psychotic disorders: United States [53], 40 percent; Canada [68], 36.6 percent for males and 26.9 percent for females; Germany [8, 44], 1.3 percent to 24 percent; Denmark [4], 43 percent; and France [69], 16 percent.

Raynault and coworkers [80] found in a Canadian sample (n = 245) that homelessness was associated with an 11.2-fold increased risk for organic psychosis and a 6.1-fold risk increase for functional psychosis. A high rate of psychotic disorders was found for nonalcoholic German men [44]. Herman and associates [81] found that 15 percent of a sample of American psychotic patients had experienced at least one episode of homelessness before or within 24 months of their first hospitalization; in more than two-thirds of these cases, the initial homeless period had occurred before the first hospitalization.

Rates of *substance abuse disorder* among the homeless are relatively high. In the United States, rates ranging from 29 percent to

50 percent have been reported [53, 57]. In the city of Calgary, Canada [61], a rate of 34 percent was recorded. The figures for Germany [43, 44] are 91.6 percent and 79.6 percent; for Norway [77], 61 percent; for France [69], 33.9 percent, and for Denmark [4, 82], 33 percent—12.55 percent for adults and 73 percent for youths.

Raynault and coworkers [80] found in a Canadian sample an association between homelessness and a 3.8-fold increased risk of substance abuse. Drake and colleagues [83] reported that 10 percent to 20 percent of homeless persons had dual diagnoses of severe mental disorder and substance abuse. As noted above, substance abuse disorder is a problem for a significant number of homeless people in Great Britain, Australia, Canada, and the United States, with a high frequency of dual diagnoses [40]. Those who had been homeless five years or more reported high rates of *alcohol abuse* and *illegal drug abuse* [73]. Craig & Hodson [32] noted also that persistent substance abuse was associated with poor outcome in terms of bringing an end to homelessness.

Drug problems, particularly use of heroin or cocaine, were reported to affect 72 percent of the homeless in the United States [56]. The next highest rate was reported for the Netherlands [35]: 50.4 percent. Rates for Canada [84], Australia [15], France [69], and Germany [44] ranged from 14 percent to 18.9 percent.

Alcohol abuse or dependence is a major factor in producing homelessness (See Table 3).

Fichter & Quadflieg [44] found that alcoholism and its consequences were more severe in a German sample (72.7 percent) than in a North American sample (51 percent). Homeless, dependent men in the American and German samples showed a high prevalence of comorbid mental disorders such as mood disorders (36.4 percent), anxiety disorders (16.4 percent), drug abuse/dependence (18.9 percent), and psychotic disorders (4.5 percent) [44]. In the German sample, a very high prevalence of alcohol dependence was also linked to schizophrenia.

In an American population, risk factors for alcohol abuse disorder included homelessness for one year or more, male gender, ethnicity other than African American, and suicidality and self-

Table 3

Homelessness and Mental Disorders: Rates in Various Countries

Alcohol abuse or dependence disorder among the homeless	Percent
USA [44, 51, 56]	51, 4–86, 51
CAN [60, 84]	60, 33
AUS [15]	74
FRA [69]	24.9
DAN [4, 82]	12–55, 33
GER [8, 43, 44]	16.7–70, 82.9, 72.7
IRE [3]	46(m), 4.1(f)
NET [35]	46
Russia [85]	60

Note: m = males; f = females.

injurious behavior [86]. Younger homeless women were found to be more likely to have alcohol problems than older homeless women [10, 55]. Among persons with comorbid mental disorders, alcohol use was somewhat greater than among other homeless persons [56]. Takano and associates [18] observed alcohol psychosis in their Japanese sample of homeless people.

Sosin & Bruni [87] found that drinking-associated problems increased vulnerability to homelessness, reduced the protection afforded by social networks against both homelessness and vulnerability, enhanced the deleterious impact of disaffiliation, and stimulated complicating health problems.

Reported rates of *schizophrenia* among the homeless were generally in the medium range (See Table 4).

In Muñoz and coworkers' [72] samples of homeless people in Madrid and Los Angeles, the Spanish sample showed a higher prevalence of cognitive impairments compared with the American group. Older homeless women have higher levels of schizophrenia than younger homeless women [10]. Half of the homeless with schizophrenia may suffer from a comorbid drug or alcohol disorder [88, 89]; and comorbid substance abuse disorders in

Table 4

Homelessness and Mental Disorders: Rates in Various Countries

Schizophrenia among the homeless	Percent
USA [6, 72]	15, 19.8
AUS [15]	15
Denmark (DAN) [4, 82]	20, 43
GER [8, 43]	1.8, 12.4
NET [35]	14
SPA [57, 72]	18, 26.1
FRA [69]	14.9
IRE [5]	33.1(m), 34.7(f)

Note: m = males; f = females.

schizophrenic persons are associated with a variety of poor outcomes, including homelessness, violence [88, 90], increased psychotic symptoms, poorer treatment compliance, medical problems (including immunodeficiency virus infection) [88], incarceration, and suicide [90]. The combination of a drug use disorder, persistent mental symptoms, and impaired global functioning at the time of hospital discharge poses a substantial short-term risk of homelessness among patients with schizophrenia [42]. When free of illicit substances and sober, homeless schizophrenic patients have a better prognosis than those who persist in their substance abuse [89].

Among subjects diagnosed with schizophrenia and related disorders, those with high levels of negative symptoms had a significantly greater risk of prehospitalization homelessness than those with low symptom levels [81]. Caton and coworkers [91], however, found in their sample that homeless schizophrenic females showed significantly higher rates of positive symptoms, higher rates of a current diagnosis of drug abuse, and higher rates of antisocial personality disorder than were observed in nonhomeless schizophrenic persons. They also had less adequate family support than nonhomeless schizophrenic women. Abram & Teplin [92] reported that most homeless, schizophrenic, criminal males met criteria for an antisocial personality disorder.

Data support the appropriateness of a diagnosis of *antisocial personality disorder* among homeless populations [93]. Personality disorders are more common in younger than in older women [10]. Raynault and and coworkers [80] found in a Canadian sample that homelessness was associated with a 3.8-fold risk increase in personality disorders. In general, reported rates for such disorders include the following: United States [53], 21 percent; Denmark [4], 36 percent for young persons and 12.55 percent for adults; Germany [8], 3.8 percent; and the Netherlands [35], 58 percent.

Discussion

Homelessness, particularly in combination with mental disorders, is a great problem in both poor and rich countries of the world. In the richest countries of the world, such as the United States and several European countries, homelessness is also a persistent concern. In the United States alone, between 4.95 million and 9.32 million persons are homeless. Families with children represent approximately 37 percent of the homeless population, and have become the fastest growing segment of the homeless [94].

It has not been easy to compare the data of relevant investigations because different diagnostic systems for the assessment of mental disorders and distinctive definitions of homelessness have been used. However, there are remarkable national differences in the prevalence rates of specific mental disorders among homeless persons. It remains obscure what the reasons are for these differences. For example, in comparison with homeless samples from other countries, many American and Dutch homeless people have drug problems. These problems among many Dutch homeless (50 percent) persons could be explained by the tolerant drug policy of the Dutch government and the related availability of drugs in the Netherlands. Yet, despite an intolerant drug policy in the United States, many American homeless persons (up to 72 percent in some samples) suffer from substance abuse disorder. Thus, there must be other reasons for the high levels of drug abuse in these populations.

In comparison with American homeless persons, Spanish homeless people demonstrate more continuous, long-term homelessness.

Muñoz and coworkers [72] hypothesize that in Southern Europe, the meaning and experience of family (support) may serve more as a protective buffer against homelessness in vulnerable Spanish persons than is the case among the vulnerable in the United States. I assume, however, that the meaning and experience of family support may serve just as much as a buffer against homelessness in American vulnerable persons as in their Spanish counterparts, so there must be another explanation for the differences between American and Spanish homeless people.

In an American sample, women and whites disproportionately reported experiences suggestive of personal and family problems. Nonwhites disproportionately reported experiences suggestive of poverty [37]. In the American sample, 67.5 percent of the homeless people were African Americans, and only 6 percent were Spanish Americans [95]. In the Netherlands sample, 42 percent of the homeless persons were Dutch, and 58 percent were of other national or ethnic origins [35]. In the French sample, 40 percent had been born abroad, mainly in Africa [69]. There are perhaps different causes of homelessness for the various ethnic groups included among the homeless persons in each country. More and more illegal foreigners from poor countries who try to improve their lot by migrating to rich Western countries become homeless and doubtless have their own specific emotional and mental problems (caused by disillusion, adaptation difficulties, culture shock, etc.).

Research is needed on the precise nature of:

—the relationship between homelessness and specific mental disorders;

—the etiology of homelessness-related mental disorders;

—national, cultural, psychosocial, genetic, and neurobiological determinants of mental disorders in specific homeless populations;

—the relationship between mental disorders and physical diseases (for example, some mental disorders characterized by impulsivity, irresponsibility, and recklessness—such as antisocial and borderline personality disorders—or impaired reality testing and/or cognitive incapacities—as in schizophrenia and psychotic disorders—may be associated with an increased risk of sexually trans-

mitted diseases (and HIV) and other health risks; furthermore, antisocial and psychopathic personality traits such as impulsivity, hostility, violence, sensation-seeking [96, 97], schizophrenia, and related disorders [98] are frequently linked to neurobiological dysfunctions);

—the impact of urban in comparison with rural environments on persons vulnerable to homelessness;

—mental and emotional problems in homeless subgroups such as females, children, and older persons, in order to devise adequate treatment and prevention programs.

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